What challenges hinder ‘peer education programmes’ when implemented to promote awareness and behaviour change within the workplace environment of Makro wholesale stores

Peter Malekhe Mangena

Assignment presented in partial fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University.

Study leader: Mr Gary Eva

December 2005

Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature: 

Date: September 2005

Summary

Why peer education projects fail in the corporate sector

Despite two decades with HIV/AIDS, there continue to be misconceptions and misinformation about proper methods to implement HIV/AIDS projects especially the peer education component.

This study was conducted based on the following reasons: “peer education is regarded by many to be suitable and effective in HIV prevention particularly in the workplace. Peer education programmes focus on members of a given group that are selected and trained to promote change within that group by acting as role models and acceptable informants. Thus, peer education is by definition adapted to the specific cultural context and can be culturally appropriate. Peer education is also a cost-effective intervention strategy, because its use of volunteers makes it inexpensive to implement (UNAIDS 1999).

This study tested the peer education programme at Makro - one of South African biggest retail chain-stores. Makro is owned by Massmart Holdings and trades through twelve large Makro Warehouse Clubs in South Africa. Their HIV/AIDS and STI programme was launched in 2004.

Peer educators from two regions – Gauteng and Port Elizabeth – participated is this study. The aim was that there would be 50% participation – that is, thirty peer educators. Peer educators from six stores within Gauteng participated in the study – as they were in easy reach of the researcher – and 25 out of 50 peer educators were interviewed face to face. However, only 4 out of 10 peer educators from Port Elizabeth responded to the questionnaire send to them through e-mail; thus a total of 29 peer educators participated in the study. The interviewed population were made out of peer educators from different levels within the stores – from human resource management, training managers, receiver managers, supervisors, shop-stewards, etc. The gender breakdown was as follows: Port Elizabeth, 3 female and 1 male; Gauteng, 22 females and 7 males. In terms of race: 1 white, 2 coloured and 26 Africans.

The findings of this study indicate that the Makro peer education programme lacks the support and buy-in of management within the stores and also at executive level. In summary, the following areas were identified from the study as major challenges: selection criteria, supervision, training acknowledgement and incentives, monitoring and evaluation, integration

and policy implementation within the workplace. These findings indicate that there is insufficient knowledge on how to go about implementing peer education project with necessary support structures in the workplace.

The study concludes with recommendations that the buy-in at all levels of management is crucial to the programme; that the peer education programme ought to be seen as a vital component of the entire business; but not as a human resource department responsibility; that the peer education programme be integrated with other existing related programmes in the workplace for sustainability; and finally proper training to those who are in charge of the programme.

Keywords: peer educator, supervision, selection, volunteer, workplace programme, biomedical approach, incentives, monitoring and evaluation, integration, sustainability

Opsomming

Waarom portuur opvoeding onsuksesvol in die korporatiewe wêreld is

Ongeag twee dekades met MIV/VIGS is daar steeds verkeerde begrip en misinformasie oor die korrekte metodes oor hoe MIV/VIGS projekte toegepas kan word veral onder portuur opvoeders.

Die uitvoer van hierdie studie is gebaseer op die volgende redes: "portuur opvoeders-programme word deur baie gesien as geskik en effektief in die voorkoming van MIV veral in die werksplek. Portuur opvoeders-programme fokus op lede van n gegewe groep wat gekies en opgelei is om veranderinge binne daardie groep te bevorder deur op te tree as rol modelle en aanvaarbare informasie bronne. Per definisie kan daar gesê word dat portuur opvoeders binne n spesifieke kulturele konteks val en ook kultureel toepaslik is. Portuur opvoeding is ook 'n koste effektiewe ingrypings strategie wwens die feit dat vrywilliges gebruik word, maak portuur opvoeding billik om uit te voer UNAIDS" (1999).

Hierdie studie het portuur opvoeding program by Makro – een van Suid Afrika se grootste kleinhandels-ketting-winkels – getoets, om te bepaal watter tipe uitdagings ervaar word deur portuur opvoeders in die Makro winkels waar hulle werksaam is. Makro is die eiendom van Massmart Beheermaatskappy en handel deur middel van 12 groot Makro Pakhuis Klubs in Suid Afrika. Hul MIV/VIGS en seksueel oordraagbare siekte programme is in 2004 bekendgestel.

Opvoeders van twee streke – Gauteng en Port Elizabeth – het in hierdie studie deelgeneem. Die doel was om 50% deelname te hê, d.w.s dertig portuur opvoeders. Portuur opvoeders van ses winkels in Gauteng het aan die studie deelgeneem – omdat hulle binne bereik van die navorser was – en persoonlike onderhoude was gevoer met 25 uit 50 portuur opvoeders. Slegs vier uit 10 portuur opvoeders van Port Elizabeth het egter gereageer op die vraelys wat aan hulle deur middel van e-pos gestuur is; dus het. 'n totaal van 29 portuur opvoeders aan die studie deelgeneem.. Die populasie wat die onderhoud ondergaan het, was verteenwoordigers uit alle werksvlakke naamlik menslike hulpbronne, opleidings bestuurders, ontvangs bestuurders, toesighouers, unie verteenwoordigers ens. Drie gender verdeling was soos volg: Port Elizabeth, sewe vrouens en een man; Gauteng, 22 vroue en 7 mans. In terme van ras: een blanke, twee kleurlinge en 26 swart persone.

Die bevindinge van hierdie studie dui aan dat die Makro portuur opvoeders-program ‘n tekort het aan ondersteuning en die inkoop van bestuur binne die winkels en ook op uitvoorraadsvlak. In opsomming, is daar gevind dat die volgende areas groot uitdagings is: seleksie kriteria, opleidings erkenning en aansporings, monitering en evaluasie, integrasie en beleids implimentering binne die werksplek.

Hierdie studie sluit af met voorstelle dat dit belangrik is dat alle vlakke van bestuur moet inkoop by hierdie program; dat die portuur opvoeders programme gesien word as n integrale deel van die totale besigheid maar nie as ‘n verantwoordelikheid van die menslike hulpbron departement nie; dat.dit met ander soortgelyke bestaande programme in die werksplek geintegreer moet word om volhoubaarheid te bewerkstellig.

Sleutelwoorde: portuur opvoeders, toesighouding, seleksie, vrywilliges, werksplek, biomediese toenadering, aansporing, monitor en evaluasie, integrasie, volhoudbaarheid.

Acknowledgements

I would like to thank the people that made this project possible. Pauline Motsodisa, from the Makro head office for ensuring that all earmarked stores received the questionnaires on time. Mpho Mofokeng, Samantha Opperman, Emily Mdluli, Agrineth Shongwe, Collin Cocking, Flora Shabangu, John Motsaneng, Evelyn Molokomme, Dorcas Ranta, Violet Lebethe and Fran Rennie from Makro stores in Gauteng for coordinating the interviews and providing me with lunch and refreshments. From Port Elizabeth, I would like to thank Siphokazi Luzipho by driving the process and ensuring that I received all questionnaires in time. Finally to all peer educators who participated in this project and the HR manager allowing time for them to be interviewed. [just for you interest: 'who' for people, 'what & that' for things. The boy who ran. The table that stood there.

I would also like to thank my three colleagues Maryna van Harmelen, Malanie Marais and Dorothy Masilo for translating my abstract to Afrikaans**,** and Dorothy Masilo for editorial assistance and motivation**.** The last word goes to my supervisor Gary Eva by leading this process until to the end, for his editorial assistance working till late hours and without his academic guidance this project would not have been possible.

TABLE OF CONTENTS **PAGE**

Glossary of Terms and Concepts

AIDS	Acquired Immune Deficiency Syndrome – a syndrome (collection of diseases) that results from infection with HIV
Evaluation	It is the systematic process of collecting and analysing data in order to determine whether and to what degree the objectives have been or are being achieved in order to make a decision
HIV	Human immunodeficiency virus – the name of the virus which undermines the immune system and leads to AIDS
Incentives	Financial and non financial compensation and reward system for peer educators
Integration	Cross-over experiences that link peer education programs with other health and development initiatives within the workplace (for example condom distribution)
Monitoring	Refers to the regular collection and analysis of information to assist timely decision-making, ensuring accountability and provides the basis for evaluation and learning
Peer education	In its broadest sense, refers to a (HIV/AIDS) programme designed to train select members of any group of equals, (office, factory, etc) to effect change among members of that same group. Peer education is a means whereby the effectiveness of a single trained educator can be multiplied
Peer educator	Is someone who belongs to a group as an equal participating member – for the purpose of the study it is a person who has received special training and information on HIV/AIDS and STIs so that this person may bring about or sustain positive behaviour change among group members

Policy	A document setting out a Department's or organisation's position on a particular issue (for example, a policy setting out the steps to be taken following occupational exposure to HIV)
Prevention programme	A programme designed to prevent HIV transmission, including components such as awareness, education and training, condom distribution, treatment of sexually transmitted infections, and occupational infection control
Selection	Is an effective way to identify peer educators whereby workers nominate co-workers within their work groups to be peer educators
STI/STD	Sexually transmitted infection or Sexually transmitted Diseases. This group of diseases includes (for example) syphilis, gonorrhoea, candidacies, genital herpes and HIV infection
Supervision	Supervision is a process whereby periodic support sessions for individuals and groups with peer educators are conducted to address HIV/AIDS related issues, stress, and burnout as well as to share successes and ideas
Support	Services and assistance related to HIV/AIDS that could be provided to help a person deal with difficult situations and challenges
Workplace programme	An intervention to address HIV/AIDS and STI issues within the workplace (for example, providing staff access to a voluntary HIV counselling and testing programme)

CHAPTER 1: Introduction

According to the workplace HIV/AIDS programme (a guide for managers) commissioned by Family Health International (FHI), June (2001) clearly states that “Successful business relies on a productive labour force. Whereas the number of AIDS death continues to rise, businesses feel the financial pinch. Some studies project losses of up to 56 percent of annual profits for selected companies in sub-Saharan Africa as a result of the HIV/AIDS pandemic. Companies incur many added expenses when employees or their families succumb to AIDS. Absenteeism soars as workers grow weak, attend funerals, or tend ailing relatives. Productivity plummets because of their absence, and the pool of available labour shrinks. Health care costs rise since companies need more healthy staff and have to pay higher medical insurance costs, life insurance premiums, disability benefits and pensions. In addition, they must hire and train new workers to replace disabled employees while covering burial costs and death benefits.: (see: http://www.FHI.org/en/HIVAIDS/pub/fact/workplace.htm)

1.1 HIV/AIDS and the private sector

The overall focus of the study is the private sector in South Africa. The researcher has selected one of the major retail stores in the country, namely Makro stores.. According to Alan Whiteside and Clem Sunter “as we have already observed, some private sector firms, particularly in KwaZulu-Natal and Gauteng, are beginning to feel the impact on AIDS.” (Whiteside & Sunter, 2000:98).

This is manifesting itself in increased illness and death in the workforce.

Family Health International (FHI) reports that retail stores lose money when credit sales are not paid off because households lack necessary funds. To cover such losses, stores must increase their prices or reduce costs, such as by laying off employees (Rau. B. FHI, 2002:8) One South African furniture manufacturer (the JD Group) has projected an 18 percent reduction in its customer base over the coming decade as a result of HIV/AIDS. In turn, retailers and manufacturers will experience a fall in sales (Rau. B. FHI, 2002:8). Of course, each company will experience HIV/AIDS in its own way.

According to a guide manual for Government Departments on managing HIV/AIDS in the workplace, titled ‘The impact of HIV/AIDS in the workplace’ (Grant, 2002), “within the workplace where many employees are HIV infected, the impact of HIV/AIDS will be experienced in many areas, such as:

• **Morbidity and absenteeism**

As infected employees become ill they take additional sick leave. This disrupts the operation of the institution for which they work. The disruption will be amplified when the more qualified and experienced employees are absent. Increases in deaths will lead to increased absenteeism, as employees attend funerals for family members, friends and colleagues. Women employees, due to their socially defined role as care givers, will have to care for sick children and partners, which may involve time off from work.

• **Mortality or retirement**

The loss of any infected employee, whether through death or retirement requires an appropriate replacement to be appointed and trained. For highly qualified staff this is often difficult, particularly in developing economies with skills shortages. Training and recruitment are costly and disrupt operations.

• **Staff morale**

The epidemic has a negative impact on morale in the workplace. There is a fear of infection and death, which may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are off sick, away from work or newly recruited and not yet fully functional.

• **Benefits**

Employers and employees will feel the impact as the cost of employee benefits increases.

• **Demand for services**

Demand for services, particularly health and welfare services, is likely to increase dramatically. This will have major implications for departments that provide these services and even more so if they already face capacity constraints or are short staffed.
(Grant, K. B 2002:15)

The case of a local sugar mill can serve as an example. “A South African sugar mill with 400 employees reported that disruption to the flow of production – because of employee absenteeism and recruitment and training of new workers – was the major cost associated with HIV/AIDS. On average, employee absenteeism during the two years prior to taking medical retirement was 27 days per year – roughly five work weeks” (Rau. 2002:21).

Table 1: ***Direct cost of HIV/AIDS per worker per year***

Reasons for cost	Cost as % of total
Hiring and training new workers	33
Lost productivity	28
Absenteeism	28
Clinical and physical visits	10
Hospitalisation	1
Total	100

(Rau, 2002:21)

Due to the impact of HIV/AIDS, as indicated above, companies are forced to come up with strategies that will reduce the impact on businesses as well as workers. Before identifying these strategies that can be applied to reduce HIV/AIDS in the workplace let's see how HIV/AIDS has an impact on households – the socio-economic impact.

1.2 HIV/AIDS impact on households

According Rau, of Family Health International (FHI), lessons that arise from experiences with workplace HIV/AIDS initiatives include "… leadership commitment demonstrated within the workplace and beyond. This is to ensure that HIV/AIDS prevention leadership at all workplace levels is conspicuous to all employees and their dependents. This can be achieved by providing adequate annual financial and logistical investments to assure that programs run effectively and efficiently. That leadership commits to programs in the community also thereby demonstrating recognition that HIV/AIDS does not stop at the company's gates." (Rau, 2002).

"HIV/AIDS not only affects workers on the job, it also causes a major drain on family savings and resources. Just as a company experiences increased expenses due to HIV/AIDS, so too does a household when members are ill with HIV/AIDS. One outcome is loss of wages, as a person becomes too sick to work. Another outcome is an increase in medical expenses to treat conditions associated with the infections. Caring for a sick family member disrupts the work schedules of others, further limiting income. Household's income and assets become an employment issue as the bulk of money is spent on medical care instead of spending equitably on other basic needs such as; food, clothing and education" (Rau, 2002).

The burden of care falls on the families and children of those who are ill. Often they have already lost a breadwinner and the meagre resources they have left are not enough to provide care for the ill person and food for family. Children who are orphaned are often

deprived not only of parental care, but also financial support. Many of them leave school and have no hope of ever getting a decent life, education or job. These children who grow up without any support or guidance from adults may become the biggest problem in the future. Our welfare system may not be able to cope with the number of orphans who need grants. Our health system is already strained to provide basic health care for all diseases and in parts of KwaZulu Natal and Gauteng almost half of hospital beds are taken by people who are ill form AIDS. AIDS can affect anyone. But it is clear that it is spreading faster to people who live in poverty and lack access to stable income due to unemployment, and who lack access to education, basic health services, nutrition and clean water.

Furthermore HIV/AIDS is still a disease surrounded by ignorance, myths, prejudice discrimination and stigma. In the workplace unfair discrimination against people living with HIV and AIDS has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employment benefits. HIV knows no social, gender, race or racial boundaries, but it is accepted that socio-economic circumstances do influence disease patterns. HIV thrives in an environment of poverty, rapid urbanisation, violence and destabilisation.

Transmission is exacerbated by disparities in resources and patterns of migration from rural to urban areas. Women particularly are more vulnerable to infection in cultural and economic circumstances where they have little control over their lives. The relationship between men and women suffer. In essence, the relation is still located in patriarchy. South Africa in particular it is still a male-dominated nation in almost all spheres; socially, economically, politically and culturally. Women are often exploited and have a more inferior status than men. In many communities women have very little control over their sexual lives, and the way to prevent sexual transmitted infections (STI's). Poverty often makes this sexual exploitation worse, and this further contributes to spread of STI's.

1.3 HIV/AIDS Prevention Intervention

According to Global Business Coalition on HIV/AIDS (GBC), the business sector can address HIV/AIDS in a wide variety of ways, from partnering with government and communities to help improve prevention and care programs, to high-level advocacy and leadership. Implementation of education programmes is essential to decrease the impact of HIV/AIDS in the workplace and community. I became interested in conducting this study because of the way the private sector is implementing their education programmes with the intention of decreaseing the impact of HIV/AIDS in the workplace.

According to the Department of Health (DOH) (Department of Health, 1997:55), "…awareness programme should provide information that is relevant, accessible in terms of the language and literacy levels of employees and which is culturally sensitive. The HIV/AIDS and STD committee has a crucial role in making sure that these principles are kept. The information should also be provided on an ongoing basis in order to make any impact".

1.4 Problem formulation

My formulation of the problem to be addressed in this study relates to the problems experienced in the implementation of HIV/AIDS projects in the workplace, particularly peer education initiatives. According to Rau, of FHI, misconceptions and misinformation persist about methods used to implement such initiatives – despite the fact that HIV/AIDS has been with us for two decades. Rau argues that there have indeed been lessons learned about what works and what does not in responding to the epidemic. We thus have "a solid basis on which to build new workplace HIV/AIDS programs or to expand existing ones." (Rau, 2002:14). Rau lists some issues that contribute to misinformation and misinformation:

- The assumption that HIV/AIDS affects only a certain class or group of people – that it is someone else's problem; assuming that infection is due to sinful or immoral behaviour;
- The assumption that a vaccine will be developed or a cure found in the near future;
- The belief that because sexual relations do not occur in the workplace that the company is 'protected'; and
- The assumption that prevention programs are too expensive.

I have used this useful list for this study, where these issues that are probed and disussed in detail.

1.5 Purpose of the study

The purpose of the study is to identify challenges that hinder the Makro HIV/AIDS and STI programme in focusing on the peer education component.

1.6 Significance of the findings

The findings of the study will be used by the relevant parties within Makro to improve the peer education component where necessary.

CHAPTER 2: Literature review

2.1 Introduction

This section will focus on previous research conducted on peer education programmes. It has already been identified from previous studies that there is a gap in documentation on the effectiveness of peer education programmes, specifically in the privatesector.

According to UNAIDS (1999b:20) “Review of the HIV/AIDS peer education literature shows that many evaluation studies document programme outputs or process indicators such as the number of peer educators trained, the number of persons in the target population contacted, and/or the number of condoms distributed by peer educators. While measurement of programme outputs is an important part of the evaluation process, it is not sufficient for understanding whether a programme has reduced vulnerability to HIV in a particular intended audience. Although they recognized the importance of conducting an impact evaluation, programme managers participating in the needs assessment cited lack of time, funding, and technical expertise as barriers to measuring behavioural and biological outcomes. In view of this, it was not surprising that only a limited number of studies were found that document programme effectiveness, as defined above, by evaluating HIV-related risk behaviours and/or STI or HIV incidence among the intended audience”.

This literature review includes the following key concepts: ‘peer education’ and ‘workplace interventions’. As very few studies have been conducted, as noted above, on challenges stipulated in this study’s research question, the literature reviewed focussed mostly on lessons learned from previous studies. The literature review also covers aspects of the impact of HIV/AIDS in South Africa, the impact in the private sector on peer education programmes in the workplace, intervention strategies to bring about behaviour change in the workplace and lessons learned from previous studies on peer education programmes. Finally the literature review explores the impact of the biomedical approach on behaviour change. The latter is argued as follows by Catherine Campbell: “Mining approaches to HIV prevention tended to rest on behavioural or biomedical responses. Behavioural responses took the form of information-based health education – which sought to persuade individual miners to change their behaviour, though providing them with factual information about health risks. Such approaches paid no attention to the way in which the social construction of sexuality would undermine the likelihood of such behaviour change by mineworkers, no matter how accurate their knowledge about sexual health risks. Biomedical responses took the form of the provision of STI clinics to treat diseases such as gonorrhoea and syphilis, which increase

vulnerability to HIV. While these clinics were run by well-trained medical experts, they made no attempt to understand or accommodate the fact that miners' understanding of STIs, and the way in which miners sought treatment for STIs, were often not consistent with the biomedical model. In short, such approaches rested on individualistic western models of health and disease, aiming their efforts at individual mineworkers, with little attempt to understand or address the social or cultural factors that made mineworkers vulnerable to STIs and HIV." (Campbell, 2003:23-24).

2.2 Defining two key concepts

Peer education

UNAIDS defines peer education as follows**:** "Peer education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. The English term 'peer' refers to "one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status…In practice, peer education has taken on a range of definitions and interpretations concerning who is a peer and what is education (e.g. advocacy, counselling, facilitating discussions, drama, lecturing, distributing materials, making referrals to services, providing support, etc.) (Shoemaker et al., 1998; Flanagan et al., 1996). Peer education typically involves the use of members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies." (UNAIDS, 1999b:5)

Workplace intervention

A workplace intervention is one designed to address a specific issue within the workplace (for example, providing staff access to a voluntary HIV counselling and testing programme)

2.3 Overview of the impact of HIV/AIDS in South Africa

"Today, about 40 million people are living with HIV/AIDS. About half live in Africa, where there are over 8,000 new infections each day. As the HIV epidemic deepens in Africa, it causes profound social and economic repercussions for communities and business. The situation is so grave that the World Bank has indicated that in parts of Africa, if effective action is not taken to combat the spread of the epidemic, HIV/AIDS could result in economic collapse." (ILO, 2005a).

According to Bloom, “Southern Africa remains the region worst-affected by the HIV/AIDS epidemic. A combination of factors seem to be responsible for this, including: poverty and social instability; high levels of sexually transmitted infections; the low status of women; sexual violence; high mobility (particularly migrant labour); and lack of leadership. South Africa has the fifth highest prevalence of HIV in the world, with 21.5% of the population estimated to be infected. The estimated number of AIDS-related deaths in South Africa in 2003 ranged anywhere between 270 000 and 520 00. Given the numbers of people infected and dying, South Africa is regarded as having the most severe HIV epidemic in the world. This epidemic is still seven years away from peaking in terms of the numbers of projected AIDS related deaths.” (Bloom (et al), 2003-2004).

It is clear that South Africa is one of the highly infected countries in Africa and despite the two decades of the presence of HIV/AIDS here, the private sector is not yet taking this situation seriously. HIV/AIDS is more severe in areas that are affected by poverty and social instability. In the case of South Africa the most highly infected communities are mostly the disadvantaged because of unemployment and socio-economic HIV/AIDS related issues.

2.4 Impact of HIV/AIDS on the private sector

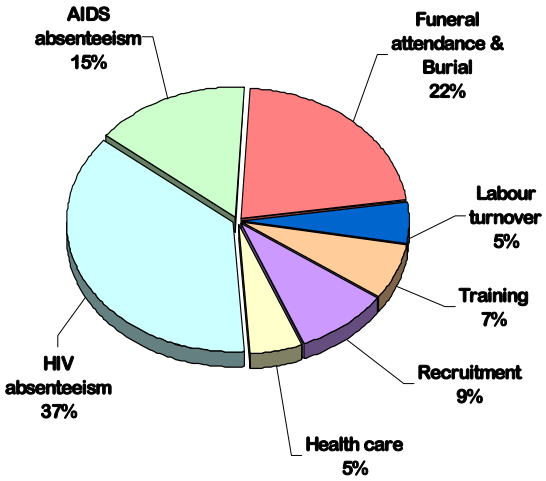
An in-depth survey on the impact of HIV/ADIS on business in South Africa was conducted by the Bureau for Economic Research (BER), for the South African Business Coalition on HIV & AIDS (SABCOHA). The survey was conducted during October and November 2003. Respondets represented the manufacturing, retail, wholesale, motor trade, building and construction sectors. According to McDonald, spokesperson for SABCOHA, “…39% of the companies surveyed indicated that HIV/AIDS has reduced labour productivity or increased absenteeism among employees. A breakdown of the results per sector shows that more than half of the manufacturers surveyed indicated that HIV/AIDS has led to lower labour productivity or increased absenteeism. In contrast, less than 20% of respondents in the retail trade indicated that HIV/AIDS has had an impact on productivity or absenteeism (SABCOHA, 2004)”.

The findings from the above survey (which involved 1006 South African companies) indicated *increased costs* as a consequence of HIV and AIDS. HIV and AIDS among employees was estimated to add up to 5.9% to a company’s annual wage and salary costs. Forty-three percent of firms envisaged significant adverse effects on their business within five years as a result of HIV and AIDS; 30% of firms reported higher workforce turnover rates and 24% increased costs of recruitment and training; 18% anticipated having to hire additional staff to compensate for changed productivity, absenteeism and mortality, while 15% were

investing in machinery or equipment to reduce their dependence on labour. (SABCOHA, 2004).

The following graph by Roberts & Rau, gives an indication of how HIV/AIDS can have an impact on the business, as already highlighted:

Graph 1: *Distribution of increased labour costs due to HIV/AIDS by category*



Roberts. M & Rau. B: Africa workshop; private sector AIDS Policy AIDSCAP.

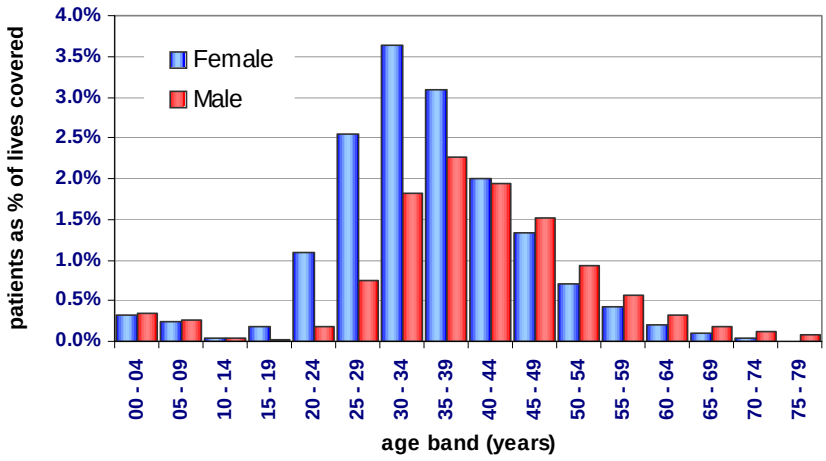
The business sector, particularly the mining industry, started to recognise the potential impact of HIV/AIDS on profits and the wider economy from the mid 1980s. Since HIV/AIDS was striking the economically active age group, companies started seeing reduced productivity, absenteeism, sickness and then deaths among the workforce.

Investing in HIV/AIDS intervention programmes with positive buy-in of management could cost companies less than ignoring the existence of HIV/AIDS. Anglo American is a good example for companies which want to implement HIV/AIDS interventions**.** "Since 2002, Anglo American, for example, has incorporated into its HIV/AIDS programme free ARV treatment for all employees who need it, and sees this as an important incentive for workers to find out their HIV status. All employees who test positive are enrolled into a wellness programme to ensure ongoing support and monitoring. The company had nearly 2500 employees on treatment by the end of 2004 and reported that 94% of them were able to carry out normal work. That year, it was costing the company more than R16 000 per patient per year to keep

employees on treatment (including all the drug, laboratory, infrastructure, training and support costs). This is seen as a sound investment compared to the financial and human cost of employees becoming sick and dying. Anglo American has identified several areas where it wants to improve the effectiveness of the programme but, along with other major employers, its experience is starting to provide important models for workplace treatment and for public/private/community partnerships in the fight against AIDS." (http://www.aids.org.za/hiv.htm/ Aids Foundation South Africa, 2005).

Age cohorts where most people die of AIDS is 20 to 45. Most of these people are productive employees and bread-winners (parents). This has serious consequences for our economy and the development of the country. According to AIDS for Aids (AfA) an HIV/AIDS Disease Management Programme under Medscheme, the age and gender distribution of members registered on the programme is as follows:

Graph 3: *AFA enrolment by gender and age*



Source: ***Aid for AIDS*** Database

Aid for AIDS is the biggest Disease Management Programme in South Africa with approximately 35 000 principle members and 2 million beneficiaries. It is clear from this graph that the highly infected group is between 20 and 49 – the economically active group. However, AfA only provides services to medical schemes and corporate institutions and these are people who are employed.

The following section focuses on effectiveness of peer education programmes and the importance of management involvement in the programme.

2.5 HIV/AIDS intervention programmes in the workplace.

2. 5. 1 Peer education

According to B Rau, of FHI, (Rau, 2002:15), the Global Business Council on HIV/AIDS – a coalition of several hundred large companies – summarises the lessons learned on how HIV/AIDS intervention should be conducted. The characteristics noted below were identified as important. This section is based on these characteristics focusing on the effectiveness of a peer education programme in the workplace.

- For a peer education programme to succeed, it needs the support of management, supervisors and employees.
- Peer educators should be appointed from across the entire spectrum of the workforce, including from management.
- A ratio of 1 peer educator to 200 employees is simply not workable. A ratio of 1:20 is probably ideal, and the distribution of peer educators should cover all sections of the workplace.
- The recruitment and training of peer educators takes time. It also takes time to monitor and supervise them once the training period is over.
- A good peer education programme should build in a regimen of continuous training for peer educators to sustain them and help remind them about what they are trying to accomplish, while enhancing their skills to aid them along the way.
- In addition, they need new materials, methods and messages in order to sustain the interest and involvement of their work colleagues.
- The assumption that employees who are peer educators are themselves HIV positive needs to be guarded against, as this can jeopardise the programme.
- Peer education programmes typically experience a turnover rate of peer educators, so it is usually necessary for the recruitment and initial training phases to be undertaken continuously.

It is important to use feedback and evaluation results to continuously inform the programme.

The objective of this section is to identify both challenges and lessons learned on the subject. The questionnaire was designed based on characteristics that make a peer education programme to be effective:

- Selection and recruitment
- Community involvement
- Training, supervision and acknowledgement
- Finding and keeping peer educators

- Programme sustainability (monitoring and evaluation)
- Integration
- Policy implementation

2.5.2 Selection and recruitment of peer educators

One effective way to identify peer educators is to have workers nominate co-workers from within their work groups to be peer educators. A significant advantage of this approach is that if employees know that they have input into the process and feel themselves to be part of it from the beginning, they will ultimately be more responsive to the program. This can have a powerful effect on behaviour change.

“Selecting peer educators who are acceptable to program staff and community members and retaining them were identified as a key challenge by needs assessment informants. Several also expressed interest in learning how other peer programs are able to retain their educators through either monetary or non-monetary compensation or other forms of motivation.” (UNAIDS, 1999a:9).

“The USAID-funded AIDSCAP programme sponsored a workshop in 1995 to review peer education programme experiences in Africa, which revealed that selecting and keeping peer educators was one of the most crucial components affecting program success.” (UNAIDS, 1999a:9).” Selection of peer educators is very crucial as highlighted. Having to deal with wrong peer educators could have a negative impact on the programme, especially if employees feel that they do not own the programme.

Additional AIDSCAP research documented the importance of peer educator characteristics as part of selection criteria: confidence, technical competency, communication skills, and compassion (Flanagan & Mahler, 1996).

The European guidelines for youth peer education programs (by Svenson, 1998) note that peer educators must be acceptable to and respected by the intended audience, with a personality conducive to training and suited to the work (UNAIDS, 1999a:9).

Two different studies by (Kelly et al. 1997; Latkin et al. 1996) mention that “… one selection strategy that is becoming popular is the use of nomination techniques and social network analysis to determine which members of the intended audience would make the best peer educators. This involves talking to members of a given group to identify whom they would

feel most comfortable talking to and receiving messages from about HIV-related issues. In the United States, such strategies have been used by HIV prevention programs among men who have sex with men (MSM) and injection drug users that have shown evidence of effectiveness". (UNAIDS, 1999a:9)

Nominating or being nominated creates ownership of the programme. It also allows co-workers to identify role-models, people they can trust and respect to represent them. Although being nominated doesn't mean one will be an effective peer educator or meet the optimal characteristics.

"The selection of peer educators is not the responsibility of the programme managers only. In order to increase the acceptability of peer educators, either in schools or at the community level, the programme mangers should involve teachers, community leaders, religious leaders and other youth organisations in the selection process of peer educators. This approach proved its success as peer educators involved in the five projects have been highly accepted and respected within their own communities and schools". (Vision 2000 Funds, 2001:17)

2.5.3 Training

According to Rose Smart, "One of the persistent problems faced by HIV/AIDS communication programmes is keeping material interesting and relevant to participants over many months. Too frequently, information is repeated to a point where audiences "tune out." NAMDEB's peer educators recognised this potential problem and employees' need for a wide range of health information. Although most Namibians know that HIV is transmitted mainly through unprotected sex, many workers are unaware of other health issues and how their own behaviours influence their health." (Rose Smart, 2004:121)

One of the challenges peer educators face is that their co-workers lose interest over a period of time because of the repetition of the same information on HIV/AIDS because of lack of creativity from peer educators. Peer education training are design to convey information but not on how to keep audience exciting about the subject. "This process often raises issues of race, gender, and class. We need to facilitate a consciousness-raising process among our staff so that they can manage not only the methodology and the content of the program but also the theoretical concepts behind it, and this may involve reviewing and potentially changing some of their attitudes. If we do not work on these issues within ourselves as a staff, the whole educational process can be distorted". (UNAID, 1999b:18)

Flanagan & Mahler (1996) of AIDSCAP, suggest that training should begin with an assessment of participants' background and experience in HIV/AIDS education before the content of the training is decided. Critical elements of peer educator training include a clear definition of the educators' expected role(s) and sufficient opportunities to practice presentations on key topics, as well as time to develop skills for correct condom use or needle hygiene. Training should also involve a written or oral exam at the end of training in order to assess competency before fieldwork begins (UNAIDS. 1999a:12-13).

Many training programs for HIV/AIDS peer educators focus primarily on 'AIDS facts' and not enough on how people in the community change HIV risk behaviour.

2.5.4 Supervision and support

According to Flanagan & Mahler, supervision helps ensure that the peer educators are doing a good job and according to them there are various ways that peer educators can be supervised:

- One-to-one visits or meeting with peer educators to answer their questions and observed them work;
- Group meeting to resolve common problems;
- Peer review of peer educator's performance;
- Observation of peer educators during their activities;
- Evaluation of peer educators' performance and feedback to them about the evaluation; and
- Monthly written or oral reports and your responses to them (Flanagan & Mahler, 1996:26).

Flanagan & Mahler, argue further that "the level of support and supervision extended to peer educators should depend on the type of activities they are doing and the amount of training they have had in these areas. In general, regular meetings with peer educators on both an individual and a group basis are recommended as are observations of peer educators during their work, progress reports submitted by them, and evaluations of peer educators' performance by supervisory staff." (UNAIDS. 1999b:29)

2.5.5 Integration

According to Solveigh Freudenthal, "The literature review indicates that peer education is seldom implemented alone. Rather it is often part of a larger, more comprehensive approach

to HIV prevention that includes condom distribution, STD management, counselling, drama and/or advocacy". (Freudenthal, 2001:17).

Peer education programmes are always seen in isolation from other activities in the workplace, whereas HIV/AIDS programmes can be integrated with existing programmes like first-aid and fire-fighting. It is clear that an integrated peer education programme is more effective and sustainable than one that is not. In their 1999 study, UNAIDS concluded that the educational activities of peer educators are almost always integrated with other programme elements such as access to condoms and/or STI testing and treatment services. (UNAIDS, 1999b:32).

A report by UNAIDS, similarly found that informants were acutely aware of the value of integration. Regarding lessons leaned, they state that "several key informants suggested that if they were to begin again they would integrate other programme components such as condom promotion, Independent Electoral Commission (IEC) materials, counselling, drama/theatre, STD services, needle exchange, legislative and policy advocacy, and care for people living with HIV/AIDS. Many key informants were particularly interested in legislative and policy advocacy, as the illegal status of target population behaviour (such as that of commercial sex workers, injecting drug users, and men who have sex with men) in some settings is a significant challenge to programme implementation." (UNAIDS, 1999b:15).

2.5.6 Monitoring and evaluation

Rose Smart suggests that most programmes/projects collect far more data than they can use. Monitoring and evaluation (M&E) systems must be as simple as possible. The more complex an M&E system, the more likely it is to fail. M&E must be built into the design of a programme. The process of establishing and implementing M&E systems can itself improve programme performance and enhance sustainability. Combining financial and programme monitoring provides a basis for sound finance/programme cross-verification. No matter how sound an M&E system may be, it will fail without widespread stakeholder "buy-in". Effective training and support for those collecting M&E data is vital for the success of M&E systems (Rose Smart. 2004:203).

Regarding monitoring and evaluation, it is important to know how many training sessions were conducted, how many people attended, how many condoms were distributed the previous year, and whether the budget needs to be increased or decreased. People going for Voluntary Counselling and Testing (VCT) and the number of STI cases reported. The

success of the programme depends on the indicators implemented in the M&E tools. Indicators are the cornerstone of M&E. An indicator is a measure of the progress made towards an objective. It can be quantitative or qualitative. It can be a process, outcome or impact indicator. It can also be a project target. Indicators should be. (Rose Smart. 2004:203):

- Simple, clear and understandable as a measure of project effectiveness;
- Reliable – conclusions based on any indicator should be the same, regardless of who, when and under what circumstances the assessment is conducted;
- Replicable, allowing for comparative analysis and potential replication of the project; and
- Available – using data that is available.

2.5.7 Role of management

For a peer education programme to succeed, it needs the support of management, supervisors, employees and union representatives. “The main challenge of utilizing peer education with factory workers is convincing factory administrators to accept the process and foresee the advantages of peer education activities; in the long run Informants stated that support from stakeholders and gatekeepers were of primary importance in many environments, such as factories or brothels, due to restrictions that make it difficult for outsiders to organize and implement educational activities. Several informants also described their frustration in working and coordinating with government agencies due to ill-defined or nonexistent policies regarding their key audiences as well as bureaucracy or lack of funding for programming” (UNAIDS. 1999:17).

Without management involvement and support the HIV/AIDS interventions will not be sustainable. It is essential that these kinds of projects are sustainable because behaviour change is something that happens over a long period of time.

2.5.8 Biomedical/Westernised approach

According to Campbell, the mining approach to HIV-prevention tended to rest on behavioural or biomedical responses. Behavioural responses took the form of information-based health education – which sought to persuade individual miners to change their behaviour, through providing them with factual information about health risks. Such approaches paid no attention to the way in which the social construction of sexuality would undermine the likelihood of such behaviour-change by mineworkers, no matter how accurate their knowledge about sexual health risks. (Campbell, 2003:23).

Recognition of the target audience's cultural beliefs is essential during promotions aimed at changing behaviour. I have seen, in most cases where I attended workshops involving traditional leaders and rural participants, that facilitators, coming from a Western perspective, criticized the traditional leaders over their adherence to traditional medicines. It was my impression that these traditional leaders thus felt alienated from the proceedings. In addition, the prevention strategies proposed by these facilitators were orientated to a particular religious perspective. One example of this orientation was that in trying to promote faithfulness to one partner, the facilitators were unaware that the participants who followed a polygamous tradition felt excluded for the proposed strategies.

Campbell makes a similar point, arguing that most HIV/AIDS strategies focus on HIV/AIDS/STI prevention and less concentration was put on mineworkers' cultural beliefs and the impact of migration and how single-man hostel may contribute to the prevalence. (Campbell, 2003:24).

To comprehend the behavioural dynamics of STD/HIV transmission, it is necessary to understand cultural constructions of women's and men's sexuality as well as the socio-economic context. A number of studies have shown the importance that gender roles play in sexual and reproductive health. Particularly, how ideologies of male dominance result in power imbalances that influence sexual risk behaviour and create barriers to behaviour change. A major criticism of some early AIDS prevention initiatives was that they failed to give enough attention to women's economic and social subordination and thus the implications for their ability to negotiate safe sex (Freudenthal, 2001:5)**.**

According to S. Freudenthal, (Freudenthal, 2001:5) "Many social scientists therefore turned away from individual risk behaviour approaches and began to investigate behaviour as guided by cultural contexts (Schoepf, 1991; Treichler, 1992; McGrath et al., 1993; Streefland, 1995; Connors & McGrath, 1997). For example, notions of what it means to be a 'real man' in a particular social context can powerfully influence sexual risk behaviour. "Real men take risks", as one man pointed out in a study from Nigeria (Orubuloye et al, 1993)".

The literature review highlights the most important aspect associated with human behaviour and change. The community is made up of different cultures, beliefs and norms and decisions made by people are determined by these different cultures. HIV/AIDS behaviour change programmes should incorporate or recognised that people may work under one roof share the same canteen but will understand and react to HIV/AIDS information differently.

CHAPTER 3: Methodology

3.1 Research question

The basic research question is: What challenges hinder 'peer education programmes' when implemented to promote awareness and behaviour change within the workplace environment of Makro wholesale stores?

3.2 Research methodology

This is a non-experimental quantitative research. According to Christensen, the primary characteristics of a non-experimental quantitative approach are that, "it is a descriptive type of research where the goal is to attempt to provide an accurate description or picture or a particular situation or phenomenon. It attempts to identify variables that exist in a given situation and, at times, to describe the relationship that exists between these variables" (Christensen, 2001).

3.3 Population and sampling

The population and sampling were based on 'haphazard sampling' because it's a non-probability technique whereby the sample of participants selected is based on convenience and includes individuals who are readily available. Considering the type of business Makro is doing I had to choose this approach because of how busy the stores are. The second advantage of using the haphazard sampling technique is that participants can be obtained without spending a great deal of time or money.

Three areas were initially chosen Gauteng, Port Elizabeth and Kwazulu-Natal. Questionnaires were sent by e-mail to Port Elizabeth and Kwazulu-Natal for educators to respond over a period of two weeks (15-29 July). Only educators from Port Elizabeth managed to respond by the due date. All six stores within Gauteng during the period of 15-29 July participated in the study as they were in reach of the researcher. Four out ten peer educators from Port Elizabeth responded to my questionnaire and twenty-five out of fifty peer educators were interviewed face-to-face in Gauteng.

Confirmation was received, late in the process, from organisers in Kwazulu-Natal that their questionnaires had already been posted; however, their arrival was too late for analysis – a lateness caused by the Post Office. Eight questionnaires were received from Kwazulu-Natal – two from Durban and six from Pietermaritzburg. These were, however, not included in the study. The sample, (which consisted of those who were interviewed in Gauteng and those

who completed questionnaires in Port Elizabeth) was made up of out of peer educators from different level within the stores, from human resource management, training managers, receiving-managers, supervisors, shop-stewards and etc.

Table 2: ***Breakdown of participants***

		Provinces				
		Port Elizabeth	**Gauteng**	**Durban**	**Pietermaritzburg**	**Total**
Participants	**Total**	4	25	0	0	**29**
Gender	**Female**	3	19	0	0	22
	Male	1	6	0	0	7
Race	**Black**	4	23			26
	Coloured	1	1			2
	White	0	1			1

3.4 Data Collection

Data collection took place during July 15-29, 2004. A due date was given to stores outside Gauteng to respond by the end of July whereas the questionnaire was send to these stores two weeks in advance.

Interviews in Gauteng started with an explanation of the nature of the study, the reason for the study and the importance of the study to Makro peer education programme. Their consent was obtained. They were all informed about the confidentiality of the study and that they may leave at any time if they do not feel comfortable during the interview.

In Gauteng, face-to-face interviews were held with peer educators who were trained in 2004 over a five-day period. The stores which participated in Gauteng were: Woodmead, Wonderboom, Germiston, Strubenvalley, Grownmines and Centurion. These interviews were conducted in the boardrooms and training rooms of the stores, to ensure privacy and no interruptions. The interviews were conducted in English and recorded in writing. The

interviews lasted between thirty and forty-five minutes. An interview guideline was used. (See Appendix A for the guideline). Respondents were questioned about their past and current experiences since the implementation of Makro HIV/AIDS and STI programme, were questioned around what they perceived to be the weaknesses in the implementation of the programme, and what they thought should be done differently. Questions were posed in a variety of different ways in order to ensure the topic was exhausted.

Because of distance questionnaires with detailed instructions were sent from Makro Head office to one store in Port Elizabeth, one in Pietermaritzburg, and two in Durban – also stating the due date. Organizers in Pietermaritzburg and Durban responded after the due, after analyis had been completed. (Six questionnaires were received from Pietermaritzburg, and two from Durban). Organizers from Port Elizabeth responded in time, sending completed questionnaires by four of their ten peer educators.

3.5 Analysis

The research data were analysed by using the process of coding. Coding enables the researcher to organise and manage large sets of data, allowing for quick retrieval and meaningful dissection, while keeping the relations between the parts intact (Miles & Huberman, 1994). In coding, data are broken down, conceptualize and then put back together in new ways (Strauss & Corbin, 1990). Coding also enables the researcher to notice the phenomena being studied, collect examples of the phenomena and final commonalities, patterns, structure and differences amongst the data (Miles & Huberman, 1994; Strauss & Corbin, 1990). The process of coding involves several stages. The stages are open coding, axial coding and selective coding (Strauss & Corbin, 1990).

The method that was used for this study was selective coding. Selective coding involves selecting the central phenomenon, obtaining examples of categories or themes, validating the relationships between categories or themes and filling in those that require further refinement (Miles & Huberman, 1994; Strauss & Corbin). To analyse the collected data I used a coding template designed from the Microsoft excel programme.

3.6 Ethics

The nature and purpose of the study was explained to respondents, who were also informed that their participation was voluntary – in order to obtain informed consent. They were assured of the confidentiality of the interviews and that names would not appear in the final report. All participants consented to being interviewed. It was explained that they could leave

at any time if they did not feel comfortable, and that during the interview they need not answer questions they did not feel comfortable to answer. They were constantly reminded that this was not an assessment of their personal performance. They were reminded of the purpose of the study, until they were at ease. They were reminded that the interview was not a personal assessment until it was felt that the respondents were at ease and comfortable. Some of the questions were repeated when they were at ease to ensure the accuracy of previous responses. The same assurances were given to respondents in Port Elizabeth – in written form.]

Chapter 4: Findings

4.1 Introduction

It is important to have knowledge of how to implement HIV/AIDS intervention programmes and of how to ensure programme effectiveness in the workplace. The following section focuses on the effectiveness of a peer education programme within Makro stores by identifying challenges Makro peer educators are currently experiencing, and have been experiencing since the launch of the Makro HIV/AIDS and STI programme in 2004. This section is divided into categories which represent what a peer education programme out to be comprised of – to be an effective programme for behaviour change within the community and the workplace environment. The sub-headings below are based a document by Flanagan & Mahler, 1996 'How to create an effective peer education project' – a guideline for AIDS prevention projects

4.2 Selection of peer educators

The following question was asked under selection and recruitment of peer educators within different stores; **'***What criterion was applied to select the peer educators in your store?'* The findings collected were as follows; 20 out of 29 reported that they volunteered to be peer educators, and 9 out of 29 reported that they were nominated by their peers or by management. In terms of stores, Woodmead was the only store where all 4 participants reported that they were nominated by their peers. There was an average of 1 in 2 in the following stores: Wonderboom, Strubenvalley and Germiston who reported that they were nominated or approached by management.

4.3 Community involvement

"Did they consider to select peer educators from the surrounding communities where employees stay (interact) after working hours? Please explain". None out of 29 reported that the involvement of the Makro peer education programme with nearby communities was not] considered or incorporated in the programme.

4.4 Availability of peer educators

In terms of availability of peer educators to conduct awareness sessions, 15 out of 29 reported that they did not experience time constraints, and 14 out of 29 fell under the category of having too much to do and were only available during tea/lunch. One peer educator reported that he could "only give 5%" because his schedule demanded 95.5 % of his time. The people who tended to be very busy are those who worked at reception and

receiving. Some of the peer educators interviewed had three different portfolios, such as shop-steward, fire-fighter and peer educator, and stated that they were too busy and consequently did not have enough time for peer education activities.

4.5 Replacement for dropouts

None of the respondents reported that there is no process in peer education for the replacement for dropouts. One peer educator from Germiston stated that they rely on the HIV/AIDS committee to handle these incidents.

4.6 Programme implementation

Under programme implementation and management, the following questions were asked: "*Are peer educators provided with responsibilities and decision-making power in the design, implementation and evaluation of the Makro HIV/AIDS and STI program (in your store)? Please explain the current process in place".*

Contradicting responses were given – 14 out of 29 reported that they did not have decision-making power regarding activities taking place in the store. They even added that their respective managements refused to disclose funds allocated to HIV/AIDS programmes in the store, and that little time was allocated to the HIV/AIDS programme. Fifteen of 29 have a say in the decision-making activities taking place in the store. The respondents reported that they also used a framework design by Jane Bruyn from head office as their guideline on what activities to conduct. The framework does not determine when and how activities should be implemented.

4.7 Goal and objective of the HIV/AIDS programme

Under this topic the following question was asked: *'Were the objective and goals of the peer education programme clearly defined and explained to you? Please explain?*

Twenty-one out of 29 peer educators reported that the goals and objectives were not clearly defined for them. Remarks included: "Makro want to know how many people are infected?", "The staffs are getting ill", "it's because they are concern about staff". The only proper explanation they received was at the training course.

Eight out of 29 claimed to have received a proper explanation of the goal and objectives of Makro HIV/AIDS and STI programme.

4.8 New opportunities

Under this topic the following question was asked: *"What new opportunities have you as a peer educator/AIDS coordinator identified since your training or implementation of the Makro HIV/AIDS and STI programme? Please explain?"*

Seventeen out of the 29 peer educators reported that they had not identified new opportunities since the implementation of the programme. Respondents from few of the stores reported on the following opportunities: positive living emphasising healthy food at the canteen; community involvement by visiting hospices and care centres; raising funds for HIV/AIDS orphans; and conducting memorial services in the store.

4.9 Content

The question asked under this topic was: *"Were you part of the decision- making process on the content or topics that need to be included (covered) for training of peer educators and was there a need analysis conducted before the training to assess your needs and expectations?"* None of 29 peer educators reported that they were not part of the decision-making process, or that they had not contributed to the content or topics covered in the training.

4.10 Training

Under this topic the following question was asked: "*Peer educators are expected to motivate and support behaviour change: what methodologies are applied to meet this requirement?"* The following methods or approaches to raise awareness in the store by peer educators were reported:

- Conduct information sessions 16
- Individual approach 9
- Create debates 1
- Circulate a questionnaire for peer to answer 1
- Invite someone who is HIV-positive 1
- No comment 1

Total **29**

Also regarding training, the following question was asked: *"Are there personal and professional growth and developmental opportunities within Makro for peer educators or as part of the Makro HIV/AIDS programme?"* None of 29 peer educators reported that there is

no growth or development for peer educators within the Makro HIV/AIDS and STI programme or within their stores.

Being a peer educator, one is faced with many challenges, especially if people start to disclose their status and a friendly environment has been created by the peer educator's initiatives. The following question addressed this challenge**:** *"If the peer educators are expected to deal with care and support of people living with HIV**,** and others affected by HIV/AIDS, what initiatives were applied to ensure that peer educators are equipped to handle anything related to support of people living with HIV and others affected by HIV/AIDS?"* None of 29 peer educators reported that this issue had not been addressed or even considered.

It might have been too soon to ask the following question because the Makro peer education programme has only been operational for one year: *"Peer educators must have continual on-the-job training and more formal refresher training. What training has been done since the initiation of the Makro HIV/AIDS and STI peer education programme?"*

Two of 29 claim to have attended training outside the workplace. The training was conducted by their community based organisations. Twenty-seven of 29 only attended the five-day peer education training in 2004. They reported that they need more training on the following: "how to make people get involved (participate) in the HIV/AIDS programme", "how to motivate them?", "We need training on industrial theatre (drama) on HIV/AIDS", "We need training on home-based care (palliative care)"

The success of the peer education programme depends on the effort the peer educators have put in. HIV/AIDS awareness projects always incorporate voluntary counselling and testing (VCT). Whether Makro is going to implement its VCT on a small scale or through a big campaign, the success of that depends on the work done by peer educators. The following question was asked: "*How many sessions have you conducted with your peers since you have been trained as a peer educator? If you have not conducted any session, please explain why not?"*

The number of formal sessions conducted per group in a store ranged from one to five over the period of a year. Time per session ranged from 30 minutes to on hour. Five hours of formal information sessions per store were conducted over a period of twelve months, which equals 25 minutes per month. The peer educators interviewed also mentioned informal sessions that they had with their peers during tea and lunch times. The reported information sessions excluded the following activities: World AIDS Day, memorial services, fund raising,

adopting an HIV/AIDS orphanage project or school. One peer educator stated that she never had a chance to speak to her peers since her training. Another peer educator stated that he had conducted 44 formal sessions since completing training. There was confusion among some of the peer educator to distinguish between conducting sessions to convey HIV/AIDS information to peers to change behaviour on the one hand, and having meetings to discuss peer education activities on the other.

4.11 Time allocated

The following question was asked: "*How much time is allocated to peer educators to raise HIV/AIDS awareness?"*

Two out of 29 reported one information session in a month is allowed and the rest (27) stated that there is no agreed time allocation within their peer education programme. According to them whenever they need to engage in activities relating to the HIV/AIDS programme in the workplace, permission is requested from management.

4.12 Supervision

Supervision is all about taking care of peer educators and supporting them. It is aptly outlined in the following definition: *Supervision is a process whereby periodic support sessions for individuals and groups are conducted with peer educators to address stress, burnout and to share successes and ideas.* The following question was asked: "*Do you have a supervision programme in place for peer educators or anything similar to the above explanation?* None of the 29 reported that they don't have a supervision programme in place.

4.13 Psychological support

The question that was asked under psychological support was: *How is the need for psychological and emotional support of peer educators, who are often exposed to stressful situations, handled?* Ten out of 29 reported that they don't know how to deal with the situation. Four reported that they would use the Employment Assistant Programme (EAP) if they needed support. The rest stated that they went to the following people for support and comfort: The occupational health-sister on site, a husband, peer educators, and one respondent stated that her mom is a nurse and she has been helpful for support and encouragement. Another respondent mentioned her aunt, who is also a nurse. One of the respondent stated that 'prayer' was her only support structure, and another claimed to sleep when frustrated.

4.14 Acknowledgement and incentives

The issue of incentives is always more debatable in community projects than workplace projects. In the workplace, peer educators are already paid a full salary and their involvement is entirely voluntary. Non-financial incentives are also very important for maintaining high levels of motivation and also for preventing dropouts. The following question was asked: "*What acknowledgement, support, incentives, compensation is given to the peer educator?"*

Twenty-four out of 29 reported that they did not receive any support whatsoever from management in terms of acknowledgement or incentives. Five respondents claimed to receive support – the following extracts indicate the sources: "management do provide us with funds and transport to visit hospice or care centres"; "I once asked to pay a visit to one of our late colleague who dead of AIDS and management provided me with transport"; "I do receive support from human resource department"; "management do provide us with badges and t-shirts as incentives". Another issue that is linked to this topic is that the success of peer education is not due to well-trained and motivated peer educators but the gatekeepers (e.g. managers, supervisors etc). The question thus posed was: *Do the peer educators receive the necessary support from management?*

Twenty-one respondents reported that management is not supportive of the peer education programme. The following extracts of responses indicate their feelings: "lack of interest from management"; "management don't give full support"; "no acknowledgement from management"; "it seems like it's a black person disease".

4.15 Monitoring and Evaluation

Monitoring and evaluation are essential components of a well-run programme.
The following question was asked: "*What tools (methods) are in place for monitoring and evaluating the Makro HIV/AIDS and STI Programme?"*

Sixteen out of 29 reported that there are no monitoring and evaluation tools in place. Thirteen out of 29 reported the following: "we submit monthly reports to head office on activities that took place", "the sister records the number of condoms distributed and Volunteering Counselling and Testing (VCT)"; "the training manager records all the activities taking place in the store and we also keep record of sessions conducted and number of people attending"; "we have a calendar of achievers for the whole year".

A template was designed by a former HIV/AIDS coordinator to rate stores' performance on a monthly basis by using three colours representing different levels of performance (green representing 'good', orange 'fair', and red 'bad'). The template covered the following areas:
plate covered the following areas:

- Management role and HIV/AIDS policy promotion
- Awareness, education and prevention
- Treatment and care
- Impact assessment
- External interaction and contributions

This information will then be reported back to stores' HIV/AIDS committees based on reports (feedback) they submitted to the HIV/AIDS coordinator.

4.16 Integration

Integration in the workplace is very crucial especially to cut costs and to avoid duplication. The following question was asked: *Are there cross-over experiences that link peer education programs with other health and development initiatives (e.g. life skills, rape crisis OHS, first-aid)?*

Twenty-two out of 29 reported that there is no integration with other health and education programmes within the stores. Seven reported that the only integration taking place is with human resource department and the sister on site.

4.17 HIV/AIDS Policy in the workplace

The following two questions were asked: "*How is your store ensuring that employees are fully informed about the HIV/AIDS policy?*"

Eleven out of 29 reported that the policy was circulated to all staff in their stores, whereas ten respondents reported that they had not received or seen the policy. Eight respondents reported on the following: "according to my understanding the HIV/AIDS policy is still a draft document." All respondents reported that the policy is in English and it has not been translated in full, or even summarised in other languages for those who cannot read English.

Chapter 5: Discussion of Findings

5.1 Introduction

In assessing the challenges experienced by peer educators during the implementation of the Makro HIV/AIDS and STI programme, the study revealed certain inadequacies on how the programme is operating and managed.

5.2 Selection of peer educators

It is evident that the majority of the peer educators were asked to volunteer. While it is important to understand that peer education programmes are based on volunteerism, the involvement of people in the programmes should be based on nomination by peers, for several reasons. By allowing co-workers to nominate peers whom they think will represent them, automatically creates ownership of the programme by all participants. Volunteering may result in defensiveness of the part of participants, as they may feel that they don't own the programme. For example, the following comments collected during the study could be linked to defensiveness: "people don't want to participate in the programme", "lots of people lost faith in the project", "people don't show interest in awareness sessions".

In a case of nomination employees are obliged to listen to the peer educators because they nominated them. Nomination of peer educators allows ownership of the programme by employees because they nominated a peer educator that they trust and represent their concerns in terms of HIV/AIDS in the workplace

From the findings, it is abundantly clear that the majority who volunteered were influenced by personal circumstances which are not clearly linked to the objectives of the Makro HIV/AIDS and STI programme. The volunteering process also created inadequacies whereby the programme ended up with peer educators who don't meet the necessary requirements to be an effective peer educator. This also indicates that that the people who initiated the process of selection did not have adequate knowledge on how to go about selecting peer educators in the workplace.

5.3 Community involvement

This issue was incorporated into this study owing to activities in the mining community. In this community, employees live in a special area, close to their work. However, Makro stores are situated within the respective central business districts. Employees travel from different townships and spend between twenty minutes to one and a half hours travelling to work.

Therefore this question may not be entirely applicable to the Makro scenario, but important for consideration when implementing a peer education programme.

5.4 Availability of peer educators

The availability of peer educators appears not to be a significant problem, as fifty-percent of respondents claimed not to have any time constraints. However, the other half do, and this again illustrates the importance of nominating peer educators. Peer educators with more than one portfolio – like a combination of union representative, fire-fighter, casher, receiver or receptionist responsibilities – find it difficult to participate fully in HIV/AIDS programmes.

5.5 Replacements for dropouts

None of the stores whose educators were interviewed or who completed the questionnaire have a replacement system for dropouts. During the interviews in Gauteng, I could pick-up that there were already some peer educators who intended to drop from the programme due to different reasons. Two of the 50 peer educators trained in 2004 resigned from the company. Except the two who resigned there was one who applied for a position at Makro head office moving him out of the store where he was actually trained to be a peer educator. Neither of the two people participated in an exit-interview to hear their views and experience about the peer education programme.

5.6 Programme implementation

Almost half of the respondents felt that they are not part of decision-making on the programme. There was strong emphasises on the lack of transparency regarding funds allocated to the programme. Respondents felt that management does not allocate enough time for HIV/AIDS awareness.

A guideline document from the head office was designed to guide peer educators on some of the activities. However, not all peer educators was aware of this. Again, this is a clear indication of a breakdown in communication between management and peer educators.

5.7 Goals and objectives of the HIV/AIDS programme

The majority of peer educators volunteered to be on the programme without knowing the goals and objectives of the Makro HIV/AIDS and STI programme. Respondents tended to assume that they would utilize personal experience and knowledge, but were, on the whole, unable to specifically state what Makro goals and objectives are.

Because the Makro programme was not clearly explained to the peer educators, they are unable to engage in activities linked to the goals and objectives of the programmes. The Makro HIV/AIDS and STI programme activities are orientated to behaviour change, but are not specifically linked to any outcome indicators.

5.8 New opportunities

New opportunities are created by interventions taking place within the workplace. The findings indicate that even after a period of twelve months, peer educators were unable to point out new opportunities created by their involvement with the HIV/AIDS programme. This clearly indicates that not enough has been done to identify the needs of Makro's target audience. The cause for this could be that the existing activities are not participatory to create or provoke questions and suggestions from the target audience. At least there should have been some new requests on other HIV/AIDS related training by now if the peer educators were fully active.

5.9 Content

The peer educators were not part of the design of the five-day training workshop. The training given covered almost everything a peer educator should know, but did not address specific needs of the target audience because a needs-analysis was not conducted.

5.10 Training

There is a perception that everyone who attended the peer education training course would automatically become a peer educator. It ought to be made clear during the selection period that people will be assessed throughout the course and a form of test then be conducted to identify those with characteristics (skills) suitable and necessary for peer education – as identified in the literature review.

The question on what methodologies are applied to promote behaviour change was not adequately answered. According to the findings, very little has been done to bring about behaviour change within Makro stores.

5.11 Time allocated

The issue of time is always a concern, especially in a production-driven environment; but it is important to put time aside because wellness of employees enhances productivity. The current haphazard approach doesn't benefit the programme at all and more meetings are

held than information sessions. The findings suggest that time is not an issue, but that it is not effectively utilised to address the need of HIV/AIDS programmes in the workplace.

5.12 Supervision

According to the findings, meetings are held on a regular basis to discuss peer education activities. None of the respondents were familiar with the word “supervision” and what it entails

5.13 Psychological support

If no support or supervision programmes are in place, then dealing with stress and burnout from the peer education programme is not addressed. It is clear from the findings that these peer educators have not yet found themselves in situations where psychological support is needed. I assume it’s because the programme is only one year old, and still at its primary phase and that peer educators re not yet burned out or dealing with stress situations that they cannot handle themselves.

5.14 Integration

HIV/AIDS has been treated in isolation for years, creating problems for people wanting to utilise whatever service is available because of the stigma surrounding it. According to the findings Human Resource department is the only department that is incorporated in the Makro HIV/AIDS and STI programme. The first-eiders, fire-fighters, the companies training department, occupational health nurse and Employment Assistant Programmes operate in isolation from the peer education programme in the stores. There is no integration processes in the stores.

5.15 Acknowledgement and incentives

Acknowledgement and recognition of peer educators is the key component for the sustainability of the programme. The findings indicate that peer educators do not feel entirely supported by the management. There is no proper framework in place for acknowledgement and incentives for peer educators. The lack of support from management has discouraged many of the peer educators interviewed.

5.16 Monitoring and Evaluation

It is impossible to implement a programme without monitoring and evaluation tools in place. Currently the programme doesn’t have clear defined monitoring and evaluation tools in place

that defines inputs, outputs and outcomes indicators. The only template available is the one designed by a former HIV/AIDS coordinator.

5.17 Policy

There appears to be consensus among respondents that a Makro HIV/AIDS policy document does exist, but whether it is approved, or only a draft is uncertain. The policy is not entirely distributed in all stores and there are peer educators who claim to have not seen the policy. There is also concern about the union involvement in the development processes of the policy. The policy is only in one language – English.

Chapter 6: Limitations and challenges

The following section looks at challenges experienced by the researcher during the study.

6.1 Study

A survey is always considered to be a cheap method for conducting research. However, it does have disadvantages. The first limitation experienced during the study was getting the necessary information to the sampling group. It was difficult for me to e-mail the information from my workplace. I had to ask someone from the Makro head office to assist me in this. Due to the large size of the document and questionnaire, my own company's security system frequently blocked it.

The second challenge was to identify someone to coordinate the process within the stores. Most people were busy with their own work-related activities and didn't have enough time to assist with this study.

6.2 Feedback

Two areas (Port Elizabeth and KwaZulu-Natal) were expected to respond to my survey questionnaire before the end 29 of July 2004. Only Port Elizabeth respondents managed to respond before the due date. When follow-up was conducted with Pietermaritzburg, the person responsible guaranteed that the questionnaires had already been posted; however, a probable delay at the Post Office saw them arrive three weeks later. The same applies to Durban, where only two people responded.

6.3 Language

I had a feeling that some of the peer educators didn't understand some of the questions asked during the interviews. This was picked up by noting some irrelevant answers. A large number of participants don't speak English as their first language, and the interviews were conducted in English. Translating could sometimes make you lose the intended meaning of your question and it took longer than an hour to do translations. As a result, it is possible that the answers may contain deficiencies. However, all attempts were made for accuracy.

Chapter 7: Conclusion and Recommendations

'My recommendations and conclusions emanate from this particular study, although the structure of this chapter is taken from a study conducted on behalf of IPPF Vision 2000 Fund (V2F) (Vision 2000 Funds, 2001'). These conclusions and recommendations take into account the findings of the above Vision 2000 study, but relate primarily to the findings of this study.

Selection of peer educators

- *Conclusion*

This study concludes that it was evident that the majority of the peer educators were asked to volunteer rather than being nominated.

- *Recommendation*

One effective way to identify peer educators is to have workers nominate co-workers from within their work groups to be peer educators. A significant advantage to this approach is that if employees know that they have input into the process and feel themselves to be part it from the beginning, they will ultimately be more responsive to the program. This can have a powerful effect on behaviour change.

Community involvement

- *Conclusion*

This study concludes that during the selection and design of the Makro HIV/AIDS peer education programme, community involvement was not considered.

- *Recommendation*

Community involvement is vital for the success of peer education programmes. Independent Electoral Commission (IEC) campaigns and promotional activities for community members, including parents, as well as community participation in the project implementation are of utmost importance for any peer education approach. In addition, working with opposition groups in the community secures a higher level of project acceptability and sustainability.

Availability of peer educators

- *Conclusion*

This study concludes that lack of time is not an issue. At least half of respondents claim to be available to do HIV/AIDS awareness, except those with more than three portfolios.

- *Recommendation*

Peer educators with more than three portfolios shouldn't be encouraged to join the peer education programme, especially shop-stewards and people who are working at receiving-stock department, reception or any demanding post.

Replacements of dropouts

- *Conclusion*

This study concludes that there is no system in place to replace dropouts.

- *Recommendation*

Alternative measures should be implemented in advance to avoid incidents whereby peer educators drop out of the programme. The stores should have a formal structure for recruiting and training new peer educators. The existing format used by human resources for recruiting, learnership, and internship could be used to avoid duplication. Exit interviews will help gauge whether reasons for people wanting to be educators are personal or programmatic. Involving current peer educators in the recruitment and training of new peer educators will also empower them and help them develop new skills. Peer education programmes should always be proactive rather than passive.

Programme implementation

- *Conclusion*

This study concludes that there is a different level of understanding of what the Makro HIV/AIDS and STI programme entails amongst peer educators and differing views regarding ownership of the programme. This is probably determined by the different levels of education amongst the peer educators, and differing understandings of how the programme should operate.

- *Recommendation*

Adopting a democratic, egalitarian, open management style and creating a worker-friendly environment are successful strategies to improve the level of communication between peer educators and programme managers, to ensure more efficient monitoring and evaluation, and to increase peer educators' motivation and retention rates.

Goals and Objectives of the HIV/AIDS programme

- *Conclusion*

This study concludes that the majority of peer educators volunteered to be on the programme without knowing the goals and objectives of the Makro HIV/AIDS and STI programme.

- *Recommendation*

Involving peer educators at various stages of the project design, implementation and evaluation, and creating a feeling of project ownership among peer educators has proved to be a very successful strategy for peer education programmes.

Peer educators' involvement in the decision-making process should go beyond the daily implementation of project activities and their opinions and suggestions should be taken into account systematically (using PDR meetings, retreats or qualitative surveys). This will enhance the commitment of peer educators and improve the programme management.

New opportunities

- *Conclusion*

This study concludes that the peer educators situated with Makro are not doing enough awareness sessions.

- *Recommendation*

A clear activity plan could be provided weekly or monthly, as well as clear identified targets to be reached are key elements to ensure that peer educators know what is expected of them. The objectives of peer educators' activities should also be in line with the short and long term project objectives of Makro (for example the role-out of anti-retroviral, and Volunteering Counselling and Testing) . Good planning will also lead to good reporting and therefore better assessment of programme performance and impact.

Content

- *Conclusion*

This study concludes that the peer educators were not part of the design of the five-day training workshop.

- *Recommendation*

It is essential to conduct a pre-need assessment or 'Knowledge Attitude Practices' (KAP) survey to know your audience's level of knowledge in terms of HIV/AIDS. This process also ensures that the necessary areas identified by the survey are addressed during training. The KAP survey can also be a measuring tool to measure improvement in knowledge, and of attitudes and practices after a certain period of time.

Flanagan & Mahler, of AIDSCAP, (Flanagan & Mahler, 1996) suggest that training should begin with an assessment of participants' backgrounds and experiences in HIV/AIDS education before the content of the training is decided

A formal training evaluation involving both quantitative (pre-post test) and qualitative (feedback from participants) data should be carefully planned. Data collected needs to be analysed to determine training needs and improve future training practices.

Training

- *Conclusion*

This study concludes that there is a perception that everyone who attends the peer education training course automatically becomes a peer educator. According to the findings very little has been done to bring about behaviour change within Makro stores.

- *Recommendations*

A successful peer educator should have the skills to act as informer, communicator, counsellor and community-based provider of condoms and other contraceptive methods. Peer educators usually face various problems and needs among their peers and therefore it is important that they have the capacity to provide help and support to their peers upon request.

A completed training curriculum should cover not only a large range of issues in Makro stores but also social and psychological aspects of sexual relationships (gender, sexual abuse, etc.), skills training (communication and counselling skills), project management, and organisational values training (familiarisation with project philosophy, the Makro HIV/AIDS policy, etc.). These topics will help trainees to increase their knowledge, develop their personality, and equip them with the necessary communication and management skills.

Time Allocation

- *Conclusion*

This study concludes that time is not an issue but it's not effectively utilised to address the needs of HIV/AIDS issue and programmes in the workplace.

- *Recommendation*

How long will worker education and prevention sessions be?

  - Half an hour?
  - One hour?
  - Two hours?

Initial worker education and prevention activities should be at least an hour in length. Less than one hour does not leave enough time for adequate information presentation, discussion, and questions and answers. Facilitated small group interactive learning activities for employees probably should not be longer than two hours, or workers may begin to

experience information overload. Formal lecture programs should be no more than one hour since lack of interaction reduces workers' attention spans. Using lectures alone should be avoided wherever possible. At a minimum, time for questions and discussion should be included. It ought to be remembered that people learn best if they have a chance to actively use and apply the information. Once workers have been through initial education sessions, subsequent sessions can be as little as thirty minutes.

Supervision

- *Conclusion*

This study concludes that there is no supervision session in place.

- *Recommendation*

Supervision is all about taking care of peer educators and supporting them. It is a process whereby periodic support sessions for individuals and groups with peer educators are conducted to address stress, burnout, and to share successes and ideas.

Supervision of peer educators' performance should include both actual peer group sessions and office-based supervisory sessions. Staff supervising peer educators must be technically competent, as well as motivational and supportive.

Psychological support

- *Conclusion*

This study concludes that the interviewed peer educators have not yet experienced serious psychological challenges owing to fewer awareness sessions conducted.

- *Recommendation*

The Employment Assistant Programme should be integrated for purposes of burnout and stress.

Integration

- *Conclusion*

This study concludes that there is no integration of the peer education programme with other activities, and the HIV/AIDS peer education programme operates in isolation from other existing programmes.

- *Recommendation*

The peer education component has to be strongly integrated with other aspects of the workplace project, and be part of the overall project philosophy. HIV/AIDS should be included

in the competence based training (CBT) courses or in the curriculum of the training department. Makro should integrate HIV/AIDS projects into the first-aid project, by applying the universal precautions, involve the Occupational Health sister for VCT and STI's, as well as linking with the human resource department to keep record of absenteeism, HIV/AIDS related death and most importantly for care and support. It is important to integrate such a project within the task of management.

Acknowledgement and incentives

- *Conclusion*

This study concludes that there is no proper framework in place for acknowledgement and incentives for peer educators. The lack of support from management has discouraged many of the interviewed peer educators

- *Recommendation*

The special reward system for best peer educators does not have to be financial. Reward and motivation systems should be discussed first with peer educators themselves to make sure that any decision will be source of encouragement rather than of discouragement..

Monitoring and Evaluation

- *Conclusion*

This study concludes that it's impossible to implement a programme without monitoring and evaluation tools in place. The Makro peer education programme doesn't have clear defined monitoring and evaluation tools in place and that defines inputs, outputs and outcomes indicators.

- *Recommendations*

Monitoring and evaluation of peer educators' activities need to be carefully planned. Monitoring procedures should not only include sessions conducted, activity reports, and regular meetings, but also feedback from the questionnaire put together by Jane Bruyn and qualitative surveys with both beneficiaries and peer educators as a way to get more relevant information about how the project and the peer educators are doing and what the urgent needs to improve the programme are.

Both process and impact evaluations have to be planned using both implementation and outcome indicators as well as quantitative and qualitative data. The evaluation tools need to be well formulated and address specific issues of peer education outputs and outcomes. It needs to be put in a context that takes into account the needs of the Makro HIV/AIDS and

STI programme, Massmart, Union and the constraints of cost and time. Otherwise, there is a risk that the evaluation becomes lost in its search of programme understanding.

Data collected for monitoring and evaluation purposes needs to be compiled, entered, analysed and disseminated systematically. It is important to check the programme achievement and performance on a regular basis and to make sure that the programme is on the right track. The comparison with baseline data will also help to track the evolution of the programme's impacts and constraints.

Policy

- *Conclusion*

This study concludes that there is consensus that a Makro HIV/AIDS policy document exists, but whether it's approved or a draft is uncertain. The policy is not entirely distributed in all stores and there are peer educators who claim to have not seen the policy. There is also concern that the union was not completely involved in the development processes of the policy. The policy is only in one language – English.

- *Recommendation*

The policy should be made available for comments and union buy-in is important. Translating it into a summary form in all relevant languages at a later stage should be put into consideration.

References

Aid for AIDS Database

Babbie. E. (1992). *The Practice of Social Research*; *(Sixth Edition).* California: Wadsworth Publishing Company,

Bloom, D.E (et al) (2003-2004). *Business and HIV/AIDS: Who me? A Global review of the Business responses to HIV/AIDS,* prepared for the World Economic Forum's Global Health Initiative in partnership with UNAIDS.

Christensen, L.B. (2001). *Experimental Methodology (8th Edition)*. Boston: Allyn & Bacon.

Davies. R. (et al) 1998. *Guidelines for developing a workplace policy and programme on HIV/AIDS and STDs:* South Africa: Department of Health.

Dickinson, D. (2003). "Managing HIV/AIDS in the South African workplace; Just another duty?" Wits Business School; *South African Journal of Economics and Management Sciences, Vol 6. No 1*. March 2003.

Flanagan, D and H. Mahler, (1996). *How to create an effective Peer Education project: Guidelines for AIDS Prevention Projects;* Arlington VA: AIDSCAP

Freudenthal, S. (2001). *A review of Social Science Research on HIV/AIDS*; for Sida/SAREC (Department of Research Cooperation).

Global Business Coalition on HIV/AIDS (GBC) (undated document). Employees and HIV/AIDS – Action for Business Leaders was developed with the help of the following GBC members; The body shop International, DaimlerChrysler SA, Eskom, Exxon Mobil, Heineken International, MTV India, Standard Chartered Bank and Unilever.

Grant.K.B (at al) (2002). *Managing HIV/AIDS in the workplace. A guide for Government Departments;* a guide manual commissioned by The Department of Service and Administration, published by Department of Service and Administration, RSA.

ILO, (2005a). *Projected labour force losses due to AIDS for 2005 and 2020*, *by region;* AIDS Factsheets and Statistics: Geneva: ILO. (See: Business and HIV/AIDS: Who Me? A

Global Review of the Business Response to HIV/AIDS 2003-2004 prepared for the Global Health Initiative in partnership with Harvard School of Public Health and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The full report is available at www.weforum.org/globalhealth/whome.)

ILO, (2005b). "The ILO Code of Practice on HIV/AIDS". *http://www.ilo.org/public/english/protection/trav/aids/code/languages/index.htm*

Kabbaj, O. (2001). *The African Development Bank calls for partnership in order to face the HIV/AIDS pandemic in Africa*. The Africa Development Bank Group. (See: Business and HIV/AIDS: Who Me? A Global Review of the Business Response to HIV/AIDS 2003-2004 prepared for the Global Health Initiative in partnership with Harvard School of Public Health and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The full report is available at www.weforum.org/globalhealth/whome.)

Maritz, J. (2001). *Innovative Approaches towards Peer Education;* University of Pretoria: Centre for the study of AIDS.

Miles, M.B. & Hubermann, A.M. (1994). Qualitative data analysis (2nd ed), Thousand Oak, Califonia: Saga.

Rau, B. (2002). *Workplace HIV/AIDS Programs: An Action Guide for Managers;***:** Arlington VA**:** Family Health International and USAID.

Roberts, M., B. Rau, and A. Emery. 1996. *Private Sector AIDS Policy: Business Managing HIV/AIDS*. Arlington, VA: Family Health International/AIDSCAP.

Rosen, S. (et al) (2004). *The cost of HIV/AIDS to businesses in Southern Africa*. Lippincott Williams & Wilkins. (See: Business and HIV/AIDS: Who Me? A Global Review of the Business Response to HIV/AIDS 2003-2004 prepared for the Global Health Initiative in partnership with Harvard School of Public Health and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The full report is available at www.weforum.org/globalhealth/whome.)

SABCOHA (South African Business Coalition on HIV/AIDS) (2004).*The Impact of HIV/AIDS on Business in South Africa***.** Kwazulu-Natal and Gauteng: Bureau for Economic Research

Smart, R. (2004). *HIV/AIDS Guide for the mining sector*; *A Resource of Developing Stakeholders Competency and Compliance in Mining Communities in Southern Africa*; Draft for Pilot Testing, published by Golden Associates Ltd.

SMARTWORK, (2004). *A Workplace Guide for Managers and Labour Leaders*: *HIV/AIDS Policies and Programs* (A publication of the Smartwork project, Center on AIDS & Community Health at the Academy for Educational Development, and is funded by the United States Department of Labour)

Strauss, A & Corbin, J. (1990). Basic of qualitative research. Newbury Park, California:

UNAIDS, (1999a) *Peer Education and HIV/AIDS: Past Experience, Future Directions,* (compiled together with the Horizons Project, and implemented with the Jamaican Ministry of Health, in collaboration with PATH, AIDSMark/PSI, ICRW, International HIV/AIDS Alliance, Tulane University, and the University of Alabama- Birmingham, IMPACT/FHI, and USAID); Alabama-Birmingham: Horizons.

UNAIDS, (1999b). *Peer Education and HIV/AIDS: Concepts, Uses, and Challenges*. Report of a consultation in Geneva, Switzerland; Washington DC: UNAIDS.

Vision 2000 Funds, (2001). *Lessons Learnt: The peer education approach in promoting youth sexual and reproductive health*, London: International Planned Parenthood Federation

Whiteside. A and Sunter. C, 2000. *AIDS The Challenge for South Africa*, Human and Rousseau Tafelberg.

Websites consulted:

http://www.peacecorner.org/programs.htm

http://www.saaf.net/peeredu.html

http://www.kathyboudin.com/ace.html

http://www.vycguyana.org/peereducation.html

http://www.world-links.org/aidsweb/peer.html

www.aids.org.za/hiv.htm

www.weforum.org/pdf/Initiatives/GHI_AfricaSnapshot.pdf

Appendix A

Peer Education Questionnaire

Research question

Challenges that hinder 'peer education programmes' when implemented to promote awareness, behaviour change within the workplace environment'.

Focus area: Makro stores.

Confidentiality and consent:

Some personal questions are asked in this questionnaire/interview schedule that some people may find difficult to answer. Your name will not be written on this form, that some people may find difficult to answer. Your name will not be written on this form, and will never be used in connection with any of the information you supply me. You do not have to answer any questions that you do not feel comfortable with, and you may end this talk/filling in at any time. However, your honest answers to these questions will help us better understand why 'Peer Education Programmes' experience challenges that led to failure or successes. I would greatly appreciate your help in responding to this interview/questionnaire. It takes about 20-30 minutes to fill in the questionnaire on your own and 20 minutes when interviewed.

The following questionnaire is targets the following people: ["is targeting" is present continuous tense, thus wrong – try to never use it]

- Peer Educators
- Peer Supervisors
- AIDS Coordinators or Project managers

NB

You are again reminded that the questionnaire is confidential. [The questionnaire is not anonymous – they know it comes from you] I promise to protect your confidentiality. Nobody will know who filled in this questionnaire.

Please avoid yes and no answers, try to explain or motivate.

Questions

Selection and recruitment of Peer Educators

Peer education programmes usually recruit (select) peer educators from the target population (employees).

R1 What criteria were applied to select the peer educators in your store?

_____

_____

_____

R2 What particular skills, previous experience or personal characteristics were sought in a peer educator?

_____

_____

_____

R3 Did they consider selecting peer educators from the surrounding communities where employees stay (or interact) after working hours? Please explain.

_____

_____

_____

Management

M1 Are peer educators given responsibilities and decision-making power in the design, implementation and evaluation of the Makro HIV/AIDS and STI program (in your store)? Please explain the current process in place.

_____

_____

_____

M2 Which new opportunities have you as a peer educator or AIDS coordinator identified since your training or implementation of the Makro HIV/AIDS and STI programme? Please explain. [if you say peer educator/AIDS coordinator, you say they are the same thing. Try never too use the /. Even HIV/AIDS is wrong – I refuse my student to use it, but rather HIV and AIDS.]

_____

_____

_____

M3 Were the objective and goals of the peer education programme clearly defined and explained to you? Please explain. [only put a question mark after a question].

_____

_____

_____

M4 Is the peer educator part of the planning of all activities currently taking place?

_____

_____

_____

M5 Were you part of the decision-making [the best from is ‘making of decisions; decision-making is acceptable, though, but because you’ve collapsed the noun and the verb, you must hyphenate] on the content or topics that need to be included for the training of peer educators, or was there a need analysis conducted before the training to utilize your needs and take your expectations into account?

_____

_____

_____

Training

T1 At the end of the peer education training what kind of test was conducted to identify those who qualify to be a Peer Educator?

_____

_____

_____

T2 Peer educators are expected to motivate and support behaviour change. What methodologies are applied to meet this requirement?

_____

_____

_____

T3 Are there personal and professional growth and developmental opportunities within Makro for peer educators as part of the Makro HIV/AIDS programme?

_____

_____

_____

T4 If the peer educators are expected to deal with the care and support of people living with HIV, and others affected by HIV/AIDS, what initiatives were applied to ensure that peer educators are equipped to handle anything related to such support.

_____

_____

_____

T5 Peer educators must have continual on-the-job training and more formal refresher training. What training has been done since the initiation of the Makro HIV/AIDS and STI peer education programme?

_____

_____

_____

T6 Interventions that only give information do not bring about risk-reducing changes in behaviour. What skills or training are in place or planned to overcome this challenge?

_____

_____

_____

T7 How many sessions have you conducted with your peers since you were trained as a peer educator? If you have not conducted any sessions, please explain why not?

_____

_____

_____

Supervision

(Supervision is a process whereby periodic support sessions for individuals and groups with peer educators are conducted to address stress, burnout as well as to share successes and ideas)

S1 Do you have a supervision programme in place for peer educators or anything similar to the above explanation?

_____

_____

_____

S2 How much supervision time do you have – (you can state this as how many sessions of supervision you have per week or per month) – and how did you come to that decision?

_____

_____

_____

S3 How is the need for psychological and emotional support of peer educators, who are often exposed to stressful situations, handled?

_____

_____

_____

S4 What acknowledgement, support, incentives, and compensation is given to the peer educators?

_____

_____

_____

S5 Are there opportunities for peer educators to teach and mentor new peer educators?

_____

_____

_____

S6 What tools are in place for monitoring and evaluating the Makro HIV/AIDS and STI Programme?

_____

_____

_____

Challenges within Peer Education Programmes

Both managers and peer educators have encountered some difficulties in Peer Education Projects.

C1 Since its implementation, what challenges could you identify regarding the Makro HIV/AIDS and STI programme in your store?

_____

_____

_____

The success of peer education is not due to well-trained and motivated peer educators but the gatekeepers (e.g. managers, supervisors etc).

C2 Do the peer educators receive the necessary support from management?

_____

_____

_____

C3 Does a peer educator's beliefs (cultural, religious, etc) interfere with their work (for example can't promote or speak about condoms because he or she is a Christian or believes in abstinence or no sex before marriage)?

_____

_____

_____

C4 How much time is allocated for peer educators to do their work per month?

_____

_____

_____

C5 Do peer educators with more than one portfolio (like shop-stewards, HR, etc) have enough time for the peer education programme activities in the store?

_____

_____

_____

C6 What replacement criteria are in place for the peer educators, especially for those who drop out or resigned?

_____

_____

_____

Integration of Peer Education Programme

I1 Are there cross-over experiences that link peer education programs with other health and development initiatives (e.g. life skills, rape crisis OHS, first-aid)?

_____

_____

_____

HIV/AIDS and Socio-Cultural issues

"Behavioural responses took the form of individual miners to change their behaviour, through providing them with factual information about health risks. Such approaches paid no attention to way in which the social construction of sexuality would undermine the likelihood of such behaviour change" (Campbell. C, 2003)

SC1 Did the peer education training you received recognise your cultural beliefs or not? Please explain.

_____

_____

_____

SC2 How do you promote HIV/AIDS awareness amongst people with low self-esteem?

_____

_____

_____

HIV/AIDS and the Law

Clearly, human rights issues are vitally important, and the struggle to achieve these rights forms a key dimension in creating a climate that is supportive of people living with HIV/AIDS. Equally clearly, the control of STIs and health education are important. Yet there is an urgent need to locate these efforts within frameworks that take into account the wider political,

social, economic and development issues which impact on HIV-prevention, and to use these expanded frameworks to inform innovative prevention efforts. [STIs is plural for STI; STI's is possessive, i.e., belonging to the STI, e.g. the STI's progression was fast].

L1 How is your store ensuring that employees are fully informed about your HIV/AIDS policy?

_____

_____

_____

L2 Is your policy available in all relevant languages?

_____

_____

_____

L3 Is the working environment **'**HIV/AIDS friendly**'** where people are told, and know, their rights?

_____

_____

_____

Thank you for completing this questionnaire!